Individualized Fitness Program Policy

Area 10 Agency on Aging offers the opportunity for community members to participate in an exercise program at the Endwright Center. This individualized fitness program includes a variety of cardiorespiratory, stretching, and resistance exercises designed to improve overall health and fitness. The goal of this program is to develop and or maintain heart and lung function, body composition, flexibility, bone density, endurance, and muscular strength. Benefits of participating in the program may include, but are not limited to, weight control, decreased resting blood pressure, reduced cholesterol, reduced stress and anxiety, and improved sugar tolerance (diabetes control). After an initial fitness orientation by the Fitness Specialist, an individualized exercise program will be created. You may not use any of the equipment offered at the Endwright Center without meeting with the Fitness Specialist for a fitness orientation.

Prior to meeting with the Fitness Specialist, the following must be on file:

1) Medical history form
2) Physician’s consent form
3) Emergency contact number

Continued Participation Requirements:
Participants are expected to inform us of any changes in health status. Each year, upon membership renewal, a medical history addendum form is required. Some health changes will necessitate getting an updated consent to exercise from your physician. This decision is made by the Endwright Center Director and/or Fitness Specialist, and is for your health and safety.

Inherent risks are associated with any exercise plan. The possible discomforts associated with exercise include dizziness, light-headedness, slight chest discomfort, leg cramps, occasional (mostly harmless) irregular heartbeats, and high blood pressure. The risk of a heart attack, although extremely small (2 in 10,000), does exist. Any time an Endwright Center client displays symptoms of a potentially serious injury or possible medical incident (e.g. stroke, heart attack, etc.), Endwright Center personnel will call for emergency medical assistance. Individualized Fitness programs are designed to reduce these risks and discomforts as much as possible. It is important to remember there is a 30 minute recovery period after exercise during which the heart is under additional strain. During this time excessive cold and heat, extended walking, and smoking should be avoided. This strain on the heart can be prevented by warming up before exercise and cooling down after exercise for at least 5 minutes.
Muscle soreness is common 1-2 days after exercising, and should disappear within a few days. This soreness is common and should not interfere with normal daily activities. If you ever experience pain that does interfere with daily activities, or lasts for more than five days, please contact your physician and inform the Fitness Specialist on your next visit to the Endwright Center. This could be a strained or torn muscle, or a more serious issue resulting from previous orthopedic issues. To avoid an injury, you may not use any of the exercise equipment without first receiving a proper demonstration from the fitness specialist.

All participants of the Endwright Center’s individualized fitness program must sign in when they enter the facility and sign out when they leave the facility. Participants are also required to locate their personal fitness plan and record their daily activities. This allows the Fitness Specialist to monitor each participant’s progress or address any concerns. When progress is made, the Fitness Specialist can adjust the individualized program to meet each participant’s needs.

Participant’s printed name _________________________________ Date ____________________

Signature of participant _____________________________________________________________________
**MEDICAL HISTORY**

Name____________________________________________  Date of Birth__________________________________________

**PRIMARY CARE**
Name of Physician________________________________     Office Phone: ______________________________________

Do you give us permission to contact your physician? ______________________________________________________

**RECENT HOSPITALIZATION HISTORY (past 2 years)**

<table>
<thead>
<tr>
<th>Age at Hospitalization</th>
<th>Reason for Hospitalization</th>
<th>Duration of Stay</th>
<th>Comments</th>
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**CURRENT MEDICATIONS**

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<tr>
<th>Medication</th>
<th>Dose</th>
<th>How Often?</th>
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**HISTORY/RISK OF HEART DISEASE/STROKE**

Please list yourself and any immediate family members (parents, siblings, aunts, uncles) who have been diagnosed with heart disease/stroke and/or who have died from heart disease/stroke.

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Type of Disease</th>
<th>Age at Diagnosis</th>
<th>Age at Death</th>
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**TURN OVER**
Have you ever been told you have high blood pressure?  □ Yes  □ No  If so, when? ______________________________________

Are you undergoing treatment?  □ Yes  □ No  If no, when did you stop? ______________________________________

Do you smoke or use any tobacco products?  □ Yes  □ No  If yes, how much and how often? ______________________

Have you smoked (used tobacco products) in the past?  □ Yes  □ No  If yes, how much and how often? __________

How many years have you smoked (used tobacco products)? ______________________ When did you stop? ______

Have you ever been told you have asthma/ respiratory health issue?  □ Yes  □ No

If yes, are you undergoing treatment?  □ Yes  □ No  If no, when did you stop? ______________________________________

What are your current cholesterol levels?  HDL ___________ LDL ___________ Total ________________

Do you have high triglyceride levels?  Yes  /  No

DIABETES

Have you ever been told you have diabetes?  □ Yes  □ No  If so, when? ______________________________________

What type of diabetes were you diagnosed with?  □ Type I  □ Type II

Are you still undergoing treatment?  □ Yes  □ No  If no, when did you stop? ______________________________________

MUSCULAR / SKELETAL PROBLEMS

Please describe any past or current orthopedic issues/injuries that may cause a concern or warrant further evaluation:

Lower extremities (foot, ankle, knee) ________________________________________________________________

Mid (hips, spine) ________________________________________________________________________________

Upper (shoulders, elbows, wrists, neck) ______________________________________________________________

Other/cont. ______________________________________________________________________________________

Are you currently undergoing physical or occupational therapy for any of these issues?  Yes  /  No

PHYSICAL ACTIVITY (past 6 months)

<table>
<thead>
<tr>
<th>Type of Exercise</th>
<th>How Long (min)</th>
<th>How Often (days/week)</th>
<th>How Hard (light/moderate/hard)</th>
<th>When did you start?</th>
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List any known allergies (including medications): ______________________________________________________

Any additional pertinent information: __________________________________________________________________

*If any of your contact information changes, or if you have any new medical conditions/health incidents, please complete the proper addendum form so we may keep your file updated and as accurate as possible.

Signature: ___________________________________________  Date: ________________________________________
PHYSICIAN CONSENT FOR USE OF FITNESS EQUIPMENT

One of your patients, _______________________________________, has expressed interest in using
the fitness equipment at our facility. In the best interest of your patient, we would like to confirm his or
her current physical and medical condition with your consent.

If you have any restrictions pertaining to this patient exercising, please list them below:

If you have any recommendations or any other comments pertaining to this patient exercising, please
list them below:

Signature of Physician ____________________________________________ Date ____________